



**DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION**

Dear Provider:

Enclosed is the District of Columbia Medicaid provider enrollment application. Please complete the application packet in its entirety. Failure to include signatures on all forms and copies of all necessary attachments will delay the processing of your application.

Return the completed application to:

**ACS Provider Enrollment
Post Office Box 34761
Washington, DC 20043-4761**

After receipt and approval of your application, you will be notified by mail of your District of Columbia Medicaid provider number. If you have any questions regarding this packet, please call Provider Enrollment toll free at 1-866-752-9231.

Sincerely,

Calvin Kearney, Chief
Program Operations
Department of Health
Medical Assistance Administration

REQUIRED ATTACHMENTS

All Providers

- ☐ W-9 Form
- ☐ Disclosure of Ownership Form

Clinics

- ☐ Current License

Day Treatment Centers

- ☐ Copy of Certificate of Need License

Dental Providers

- ☐ Current License
- ☐ Malpractice Insurance Certificate of Coverage
- ☐ DEA License

DME Providers

- ☐ Certificate of Occupancy
- ☐ Business License

Home Health Providers

- ☐ Current License

Hospitals & Residential Treatment Centers

- ☐ Current Certification/Licensure in Local Jurisdiction
- ☐ Liability Insurance
- ☐ Current JCAHO Accreditation Letter
- ☐ Residential Treatment for Children and Adolescents Supplement (not applicable for hospitals)

Independent Labs

- ☐ List of Category/Sub-Category Tests and/or Procedures which the lab is certified to render under Medicare (Title XVIII)
- ☐ List of Usual and Customary Charges for each Test/Procedure certified by Medicare (Title XVIII)
- ☐ Most recent CLIA Certificate
- ☐ Current Licenses for all clinicians

Pharmacists

- ☐ DC Controlled Substance
- ☐ DEA License
- ☐ DC Pharmacy License
- ☐ CMS Letter

Physicians/Opticians

- ☐ Current License

Transportation Providers

- ☐ Current WMATC Certificate of Authority
- ☐ Current WMATC Certificate of Insurance and Policy Endorsement
- ☐ Copies of Current Driver's Licenses for all vehicle operators
- ☐ Copies of Current CPR and First Aid Certification for all vehicle operators
- ☐ Criminal Background Check submitted for all proposed drivers (conducted within 60 days of submission)
- ☐ Drug Test Results submitted for all proposed drivers (conducted within 60 days of submission)
- ☐ Recent Vehicle Inspection (no older than 3 months)
- ☐ Copy of Vehicle Registration for all proposed vehicles

Optional

- ☐ Direct Deposit Application
- ☐ EDI Application (electronic billing) – available upon request

Please check (✓) your provider type. This application is limited to one provider type. To apply for more than one provider type, separate applications must be submitted.

	Adult Day Care		Home Health Agency
	Alcohol and Substance Abuse Clinic		Hospice
	Ambulance Transportation		ICF/MR
	Ambulatory Surgery Center		Independent Lab
	Assisted Living (Pending)		LTAC Hospital
	Audiologist		Mental Health Clinic
	Birthing Center		Nurse Practitioner
	Case Manager		Nursing Facility
	Community Residential Facility		Optician
	Day Treatment		Optometrist
	DC Public Schools		Other Medical Transportation
	Dental Clinic		Pharmacy
	Dentist*		Physician DO*
	DHS Dental Clinics		Physician MD*
	DME Provider		Podiatrist
	Emergency Access Hospital		Private Clinic
	Family Planning Clinic		Psychiatric Hospital Private
	Federal Quality Health Center		Psychiatric Hospital Public
	Freestanding Radiology		Public Charter Schools
	General Hospital		Public Health Center
	Hearing Aid Dispenser		Radiation Therapy Center
	Hemodialysis Center – Freestanding		Rehabilitation Center
	HMO		Residential Treatment Center
	Home Community Based Waiver*		

*If you are a medical doctor, a doctor of osteopathic medicine, a dentist, or an institution that renders such services, please review and check the applicable specialty from the list provided below.

MD or DO Specialties

	Allergy		Internal Medicine		Mental Health Case Mgmt
	Anesthesiology		Neonatal		Neuro Surgery
	Cardiovascular		Nephrology		Ortho Surgery
	Colon and Rectal Surgery		Neurology		Pediatrics
	Dermatology		Nuclear Medicine		Physical Medicine & Rehab
	Emergency Medicine		OB/GYN		Plastic Surgery
	Family Practice		Obstetrics		Psychiatry
	Gastroenterology		Ophthalmology		Pulmonary Disease
	Genetics		Osteopathy		Radiology
	Geriatrics		Otolaryngology		Rheumatology
	Gynecology		Pathology		Thoracic Surgery
	Hematology/Oncology		Preventive Medicine		Urology
	Infectious Disease		General Surgery		Vascular Surgery

Dental Specialties

	General Dentistry		Orthodontist		Endodontist
	Oral Surgery		Periodontist		Prosthodontist
	Pedodontist				

Home Community Based Waiver Specialties

	Consultants & Professionals		Hands-On Direct Care Services
	Case Management		Personal Care Aide
	Speech, Hearing & Language Therapy		Homemaker
	Nutrition Counselor		Respite
	Caregiver Education/Family Training		Attendant Care Aide
	Preventive & Consultative Crisis Intervention		Chore Aide
	Skilled Nursing		Companion
	Dental		Habilitation Services
	Physical Therapy		Residential Habilitation
	Occupational Therapy		Day Habilitation
	Assistive Adaptive Services		Prevocational Habilitation
	Personal Emergency Response		Independent Habilitation
	Environmental Accessibility Adaptation		Supportive Employment Habilitation
	Adaptive Equipment		Transportation



**DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION**

PROVIDER APPLICATION FORM

Please type or print. Incomplete applications will not be processed.

**SECTION 1
APPLICANT INFORMATION**

Check the appropriate box below and complete the associated information.

☐ Individual

Name (Last, First, Middle) _____

Doing Business As _____

Telephone _____ Fax _____

Email _____

☐ Group

Group Name _____

Doing Business As _____

Contact Name _____

Telephone _____ Fax _____

Email _____

☐ Facility

Facility Name _____

Doing Business As _____

Contact Name _____

Telephone _____ Fax _____

Email _____

Have you or your organization ever enrolled in DC Medicaid?

☐ Yes ☐ No

If Yes, please complete the following:

DC Medicaid Provider Number _____

SECTION II OFFICE INFORMATION

Primary Office Street Address _____

City/State/Zip _____ Ward _____

Office Telephone(s) _____ Office Fax _____

Office Email _____ Office Manager _____

Correspondence Address _____

City/State/Zip _____

Type of Practice (L.L.C., Corp., etc.) _____

Group/Corporate Name _____ Federal Tax ID _____

Medicare # _____ Medicaid # _____

Please list other licensed/certified professional members of your practice:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (circle one)

Accept new patients into your practice? Y N

Accept new patients from referral only? Y N

Does the office: (circle one)

Have 24-hour telephone coverage? Y N

Have capability for electronic billing? Y N

Does this location have TDD? Y N

Have public transportation access? Y N

Meet Americans with Disabilities

Act accessibility standards? Y N

Please complete this page if you have an additional office.

Primary Office Street Address _____

City/State/Zip _____ Ward _____

Office Telephone(s) _____ Office Fax _____

Office Email _____ Office Manager _____

Correspondence Address _____

City/State/Zip _____

Type of Practice (L.L.C., Corp., etc.) _____

Group/Corporate Name _____ Federal Tax ID _____

Medicare # _____ Medicaid # _____

Please list other licensed/certified professional members of your practice:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (circle one)

Accept new patients into your practice? Y N

Accept new patients from referral only? Y N

Does the office: (circle one)

Have 24-hour telephone coverage? Y N

Have capability for electronic billing? Y N

Does this location have TDD? Y N

Have public transportation access? Y N

Meet Americans with Disabilities

Act accessibility standards? Y N

**SECTION III
BILLING INFORMATION**

Payment Address _____

City/State/Zip _____

Remittance Address _____

City/State/Zip _____

What type of media are you using for billing today (i.e., electronic, manual, etc.)?

Do you bill for diagnostic radiology or clinical laboratory services under your supervision? ☐ Yes ☐ No

If Yes, please indicate the following:

☐ Radiology or ionizing services ☐ Clinical laboratory services

CLIA # _____

**SECTION IV
PROFESSIONAL LICENSURE**

List all current professional licenses. Please attach copies.

State	Type	Number	Issue Date	Expiration Date

SECTION V CERTIFICATIONS/REGISTRATION

Please attach copies of any of the following certifications if held. Attach a separate sheet if necessary.

Federal DEA Registration Number _____

Date Issued _____ Expiration Date _____

State CDS Number _____ State _____

Date Issued _____ Expiration Date _____

CPR certified? ☐ Yes ☐ No Expiration Date _____

If Yes, list classifications _____

International Graduates: Are you ECFMG certified? ☐ Yes ☐ No

USMLE/ECFMG Number _____ Issue Date _____

Nursing Professionals: Please list any certifications held

Certification	Received From	Expiration (MM/YY)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SECTION VI
SPECIALTY INFORMATION**

Primary Specialty _____ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name _____ Date of initial certification _____
Board Certification expires? ☐ Yes ☐ No If Yes, date of expiration? _____
Have you been recertified? ☐ Yes ☐ No If Yes, date of recertification? _____
If Qualified, when does status expire? (MM/YY) _____
Board certification results pending? ☐ Yes ☐ No

Sub-Specialty _____ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name _____ Date of initial certification _____
Board Certification expires? ☐ Yes ☐ No If Yes, date of expiration? _____
Have you been recertified? ☐ Yes ☐ No If Yes, date of recertification? _____
If Qualified, when does status expire? (MM/YY) _____
Board certification results pending? ☐ Yes ☐ No

Sub-Specialty _____ ☐ Qualified ☐ Certified ☐ Not Applicable
Board Name _____ Date of initial certification _____
Board Certification expires? ☐ Yes ☐ No If Yes, date of expiration? _____
Have you been recertified? ☐ Yes ☐ No If Yes, date of recertification? _____
If Qualified, when does status expire? (MM/YY) _____
Board certification results pending? ☐ Yes ☐ No

SECTION VII BEHAVIORAL HEALTH PROVIDERS/PRACTITIONERS

If you practice Behavioral Health, please complete this section. Please attach copies of any certifications held.

- Do you offer emergency appointments (within 24 hours of call)? ☐ Yes ☐ No
- Do you treat younger children (age 0-5)? ☐ Yes ☐ No
- Do you treat older children (age 6-12)? ☐ Yes ☐ No
- Do you treat adolescents (age 13-17)? ☐ Yes ☐ No
- Do you treat adults (age 18-65)? ☐ Yes ☐ No
- Do you treat geriatric patients (age 65 and older)? ☐ Yes ☐ No
- Do you provide family therapy? ☐ Yes ☐ No
- Do you provide group therapy? ☐ Yes ☐ No
- Do you provide crisis evaluation/intervention services? ☐ Yes ☐ No
- Are you available to see clients at least 4 full days a week? ☐ Yes ☐ No
- What is the average waiting time to obtain an appointment? _____

SECTION VIII DENTAL PROVIDERS/PRACTITIONERS

If you are a Dental Provider, please complete this section. Please attach copies of any licenses held.

Licensure Status (please check all that apply and indicate licensure information in Section V)

- ☐ General dental license ☐ Limited dental license ☐ Teacher's dental license
- ☐ Inactive dental license ☐ Other _____

Are you recognized as a Specialist by the Dental Board? ☐ Yes ☐ No

If Yes, please specify _____

Do you hold a permit to administer general anesthesia? ☐ Yes ☐ No

Do you hold a permit to administer conscious sedation? ☐ Yes ☐ No

Do you utilize nitrous oxide in your practice? ☐ Yes ☐ No

SECTION IX HOSPITALS/FACILITIES

If you are a hospital or facility, please complete this section.

Name of Facility/Institution _____

Type of Facility/Institution _____

Name of Administrator _____

Telephone Number _____

Name of Medical Director _____

Telephone Number _____

Licensed Bed Capacity (if applicable) _____

Name of Comptroller (if applicable) _____

Telephone Number _____

Facility/Institution License Number _____

State _____ Effective Date _____

Tax Identification Number _____

Drug Enforcement Agency (DEA) Number _____

Is the facility/institution Medicare certified? ☐ Yes ☐ No

Accreditation Date (if applicable) _____

Medicare Provider Number _____ Medicare Effective Date _____

UPIN (if applicable) _____

Please enter 1 for services provided by staff and enter 2 for services provided under contract.

___ Clinical Laboratory ___ Dentistry ___ Diagnostic Radiology

___ Educational ___ Nursing ___ Occupational Therapy

___ Outpatient Speech Pathology ___ Pharmacy ___ Physical Therapy

___ Podiatry ___ Psychological Services ___ Recreational Activities

___ Speech Pathology ___ Other Services _____

Name of Peer Review Organization (PRO) services organization _____

Address _____

Telephone Number _____

**SECTION X
OUT OF STATE HOSPITALS/FACILITIES**

If you are an out-of-state hospital or facility, please complete this section in addition to Section IX.

Type of Service	Percent of Charges	Per Diem or Visit All-Inclusive	Fee for Service	Effective Date
Inpatient				
Outpatient				
Emergency Room				

Are physician services and components included in your cost?
Separately?

☐ Yes ☐ No

☐ Yes ☐ No

**SECTION XI
PHARMACY PROVIDERS**

If you are a pharmacy provider, please complete this section.

Name of Pharmacy _____

Doing Business As _____

Chief Pharmacist _____

Title _____ Phone _____

Please list information for all pharmacists providing services at your location.

Name of Pharmacist	License Number	State

Occupancy Permit Number _____

NABP Number _____ NABP Effective Date _____

Please list any additional services, excluding drugs, that are provided to the District Medicaid recipient.

SECTION XII TRANSPORTATION PROVIDERS

If you are a transportation provider, please complete this section.

Check one or more of the following boxes to indicate whether your company has obtained authority to transport passengers for hire from any federal or state agency.

- ☐ Provider has not obtained authority to transport passengers for hire with any agency.
- ☐ Provider has obtained authority from the Washington Metropolitan Area Transit Commission (WMATC).
- ☐ Provider has obtained authority from the Maryland Public Service Commission (MDPSC).
- ☐ Provider has obtained authority from the State of Virginia Department of Motor Vehicles.

Check the box that corresponds to the amount of automobile insurance currently in force for your company.

- ☐ \$1.5 million ☐ \$5 million ☐ Other (\$ _____) ☐ Uninsured

Does your company have a current safety rating from the United States Department of Transportation (USDOT) or the Federal Highway Administration? ☐ Yes ☐ No

If Yes, what is the rating? _____

If the rating was satisfactory or conditional, please attach the notice of safety rating.

Check all that apply.

- ☐ Ambulance ☐ Wheelchair Equipped Van ☐ Stretcher
- ☐ Taxicab ☐ Other, please describe _____

Please complete the table below for all vehicles in your fleet. Attach additional pages if necessary. Maximum seating capacity should include driver and assistant and include ambulatory (A) vs. non-ambulatory (W) wheelchair loads (i.e., 3 wheelchairs and 6 ambulatory).

Fleet Vehicle Number	Type of Vehicle as defined above	Vehicle Identification Number	Make and Model of Vehicle	License Plate Number	Maximum Seating Capacity	Is vehicle owned or leased?

Please list all motor vehicle operators who will be employed in the transporting of DC Medicaid patients – not applicable to air transportation providers. Attach additional pages if necessary.

Full legal name of operator	Age of operator	Driver's License Number & jurisdiction issued	Vehicle number in which operator will be assigned	Background check performed?	Drug screening performed?	Is vehicle owned or leased by carrier?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION XIII VISION PROVIDERS/PRACTITIONERS

If you are a vision provider, please complete this section. Please attach copies of any certifications held.

Which of the following are you certified to use or prescribe?

- ☐ Topical Ocular Diagnostic Pharmaceutical Agents
- ☐ Therapeutic Pharmaceutical Agents
- ☐ Diagnostic Pharmaceutical Agents

Does your office have an on-site lab?

☐ Yes ☐ No

SECTION XIV HEALTH CARE FACILITY AFFILIATIONS

List all health care facilities where you currently have privileges, beginning with the most recent. Please attach a separate sheet if necessary.

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) ☐ Yes ☐ No

Is this your Primary Facility? ☐ Yes ☐ No

**SECTION XV
GROUP AFFILIATIONS**

Group Name _____

Doing Business As _____

Address _____

Telephone Number _____

As a group practice, please list providers below. Attach additional sheets if necessary.

Provider Name	Current Provider Number

Group Name _____

Doing Business As _____

Address _____

Telephone Number _____

As a group practice, please list providers below. Attach additional sheets if necessary.

Provider Name	Current Provider Number

SECTION XVI
PROFESSIONAL LIABILITY INSURANCE COVERAGE

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name _____
Carrier Address _____
Agent Name _____ Policy Number _____
Policyholder _____
Amount of Coverage _____
Coverage amount per occurrence Coverage amount per aggregate
Dates of Coverage From _____ to _____
Type of Coverage ☐ Claims Made ☐ Occurrence

Carrier Name _____
Carrier Address _____
Agent Name _____ Policy Number _____
Policyholder _____
Amount of Coverage _____
Coverage amount per occurrence Coverage amount per aggregate
Dates of Coverage From _____ to _____
Type of Coverage ☐ Claims Made ☐ Occurrence

Carrier Name _____
Carrier Address _____
Agent Name _____ Policy Number _____
Policyholder _____
Amount of Coverage _____
Coverage amount per occurrence Coverage amount per aggregate
Dates of Coverage From _____ to _____
Type of Coverage ☐ Claims Made ☐ Occurrence

SECTION XVII
MALPRACTICE CLAIMS HISTORY

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent. Attach additional sheets if necessary.

☐ None

Date of Occurrence _____ Date Claim Filed _____

Professional liability carrier involved _____

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _____

Describe the allegations against you _____

Describe the alleged injury to the patient _____

Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No If Yes, Date Filed _____

State Court Case Number _____ State _____ County _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the claim/case

<input type="checkbox"/> Pending	<input type="checkbox"/> Settled	<input type="checkbox"/> Arbitrated	<input type="checkbox"/> Awarded
<input type="checkbox"/> In Appeal	<input type="checkbox"/> Adjudicated	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Other _____

Please provide additional information/explanation (e.g., the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XIX.

Date of Occurrence _____ Date Claim Filed _____

Professional liability carrier involved _____

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _____

Describe the allegations against you _____

Describe the alleged injury to the patient _____

Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No If Yes, Date Filed _____

State Court Case Number _____ State _____ County _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the claim/case

<input type="checkbox"/> Pending	<input type="checkbox"/> Settled	<input type="checkbox"/> Arbitrated	<input type="checkbox"/> Awarded
<input type="checkbox"/> In Appeal	<input type="checkbox"/> Adjudicated	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Other _____

Please provide additional information/explanation (e.g., the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XIX.

SECTION XVIII
ADDITIONAL QUESTIONS

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? ☐ Yes ☐ No
2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? ☐ Yes ☐ No
3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? ☐ Yes ☐ No
4. Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, or placed on probation? ☐ Yes ☐ No
5. Have you ever been placed on probation or asked to resign from an internship, residency or other training program? ☐ Yes ☐ No
6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violation? ☐ Yes ☐ No
7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? ☐ Yes ☐ No
8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled)? ☐ Yes ☐ No
9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐ Yes ☐ No
10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? ☐ Yes ☐ No
11. Are you engaged in the illegal use of drugs? ☐ Yes ☐ No
12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? ☐ Yes ☐ No
13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? ☐ Yes ☐ No

14. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No

15. Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly? ☐ Yes ☐ No

If so, please provide the following information:

Name of Organization	Type of Organization
Mailing Address of Organization	
Telephone Number	Tax ID Number
Percent of Business Owned/Invested by You	Nature of Business Investment (owner, partner, investor, etc.)

IF YOU ANSWERED “YES” TO ANY OF THE ABOVE, PLEASE PROVIDE AN EXPLANATION FOR EACH AFFIRMATIVE RESPONSE IN SECTION XIX.

SECTION XIX EXPLANATION

Please use this space to provide any necessary explanation from previous sections. Please indicate the Section and question number.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

SECTION XX
AUTHORIZATION TO RELEASE INFORMATION
AND AFFIRMATION

I authorize the DC Medical Assistance Administration and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release the carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the carrier.

Applicant Signature

Date

Applicant's Printed Name

Telephone

Mailing Address



**DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION**

MEDICAID PROVIDER AGREEMENT

Name of Provider _____

Address _____

Title XIX Provider Number _____

This Agreement, made and entered into this _____ day of _____, 20 ____, by and between the District of Columbia Department of Health, hereinafter designated as the Department, and the above-named, a Provider of Services, whose address is, as stated above, hereinafter designated as the Provider.

Witnesseth:

WHEREAS, persons receiving public assistance payments from the Department of Health and other persons eligible for care and under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care;

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires the District of Columbia to enter into written agreement with every person or institution providing services under the State's Plan for Medical Assistance (Title XIX);

WHEREAS, pursuant to Commissioner's Order 70-83 and PL-90-227 which makes the DC Department of Health the agency responsible for administering the Medical Assistance Program (Title XIX) in the district of Columbia, and authorize the Department of Health to take all necessary steps for the proper and efficient administration of the District of Columbia Medical Assistance Program;

WHEREAS, to participate in the District of Columbia Medical Assistance Program, the provider when applicable, must: (1) be licensed in the jurisdiction where located and/or the District of Columbia; (2) be currently in compliance with standards for licensure; (3) services be administered by a licensed or certified practitioner; and, (4) comply with applicable Federal and district standards for participation in Title XIX of the Social Security Act, and;

WHEREAS, prospective provider has filed an application with the Department to provide medical services to persons eligible under the Medical Assistance Program operated under Title XIX of the Social Security Act and said application is incorporated by reference into this Agreement and made a part hereof the same as if it were written herein.

The Provider agrees:

I. GENERAL PROVISIONS

- A. To provide to Medicaid patients, services as covered in Title XIX of the Social Security Act and the State Plan of Medical Assistance.
- B. To accept as payment for supplying the services in “A” above, a reimbursement rate calculated in accordance with the District State Plan for Medical Assistance;
 - 1. The provider’s payment shall be accepted as payment in full for the care of the patient, and;
 - 2. No additional charge shall be imposed on the patient, member of his family or to another source for any supplementation for any time except as allowed within Federal and District regulation.
- C. To satisfy all requirements of the Social Security Act, as amended, and be in full compliance with the standards prescribed by Federal and State standards.
- D. To accept such amendments, modifications or changes in the program made necessary by amendments, modifications or changes in the Federal or State standards for participation.
- E. To comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, 42 CFR Parts 80, 84 and 90, the Americans with Disabilities Act, P.L. 101-336, any amendments thereto and the rules and regulations there under.
- F. To maintain all records relevant to this Agreement at his/her cost, for a period of six years or until all audits are completed, whichever is longer. Such records shall include all physical records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to covered Medicaid recipients.
- G. To provide full access to these records to authorized personnel of the Department, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives for audit purposes.
- H. To furnish upon request to the Medicaid agency, the Federal Government or their designees, information related to business transactions in accordance with 42 CFR & 455 105(b);
- I. To hold harmless the District of Columbia Government, the Department and Medicaid recipients against any loss, damage, expense and liability of any kind arising out of any action of the provider or its subcontractors arising out the performance of this agreement.
- J. To comply with the advance directive requirements contained in 42 CFR, Part 489, Subpart I, as appropriate.
- K. To complete and sign a Provider Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the

understanding that the application becomes a part of this agreement and that each succeeding change in the application constitutes an amendment to the Agreement and failure to keep the information current constitutes a breach of the Agreement.

a. To provide assurances of compliance with:

D.C. Law 12-238 which prohibits Medicaid providers from offering employment or contracting with any person who is not a licensed healthcare professional until a criminal background check has been conducted for the person and also prohibits any facility from employing or contracting with any person who has been convicted of certain criminal offenses specified in the law;

42 USC § 31306 and 49 CFR 382 which requires employers of commercial drivers to conduct pre-employment, reasonable suspicion, and post-accident testing for controlled substances; and,

The Drug-Free Work Place Act of 1988 (21 USC § 701 et seq.), which requires the implementation of an alcohol and drug-testing program.

b. That any breach of violation of any one of the above provisions shall make this entire Agreement, at the Department's option, subject to immediate cancellation or imposition of enforcement remedies in conformance with Federal and District laws and regulations.

II. REQUIRED INFORMATION

- A. A description of ownership and a list of major owners (stockholders owning or controlling five percent or more outstanding shares);
- B. A list of Board members and their affiliations;
- C. A roster of key personnel, their qualifications and a copy of their position descriptions. Key personnel including: the President and Vice-President, Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Director of Nursing, Director of Quality Improvements/Quality Assurance;
- D. Copies of licenses and certifications for all staff providing medical services;
- E. The address of all sites at which services will be provided to Medicaid recipients;
- F. Copy of the most recent audited financial statement of the organization;
- G. A completed provider application;
- H. A copy of the basic organizational documents of the provider, including an organizational chart and current articles of incorporation;
- I. A copy of the by-laws or similar documents regulating conduct of the provider's internal affairs;
- J. A copy of the business license;

- K. A copy of Joint Commission on Accreditation of Health Care Organization's certification;
- L. A copy of Certificate of Need approval; and,
- M. The submission of any other documentation deemed necessary the Department for the approval process as a Medicaid Provider.

III. CONTRACT AND SUBCONTRACTS

- A. The Department or the provider may terminate this Agreement for convenience by giving 90 days written notice or intent to terminate the Agreement to the party.
- B. The provider shall be legally responsible for all activities of its contractor and subcontractors and for requiring that they conform to the provisions of this Agreement. Subject to such conditions any service or function required by the provider pursuant to this Agreement may be subcontracted to any person or organization who/which meets all Federal and District requirements for participation in Medicaid, whether or not they are enrolled as Medicaid providers.
- C. Sub-contractual agreement with providers who have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act is prohibited. Services provided to Medicaid eligible recipients through such subcontracts shall not be eligible for reimbursement by the Department.
- D. The Department reserves the right to require the Provider to furnish information relating to the ownership of the subcontractor, the subcontractor's ability to carry out the proposed obligations, assurances that the subcontractor shall comply with all applicable provisions of Federal and District law, and regulations pertaining to Title XIX of the Social Security Act and the State Plan for Medical Assistance and with all Federal and District laws and regulations applicable to the service or activity covered by the contract; the procedures to be followed by the provider in monitoring or coordinating the subcontractor's activities and such other provisions as the Department or the Federal Government may reasonably require.
- E. Each subcontract shall contain a provision that the subcontractor shall look solely to the provider for payment of covered services rendered

IV. PAYMENT TO PROVIDER

- A. The Department shall reimburse providers for services to eligible Medicaid recipients in accordance with the District's State Plan of Medical Assistance.
- B. The provider shall submit invoices for payment according to the Department's requirements.
- C. The Department shall make payments to the provider in accordance with applicable laws, as promptly and as feasible after a proper claim is submitted and approved.

- D. The Department shall notify the provider of any major changes in Title XIX rules and regulations and in the State Plan of Medical Assistance.

V. THIRD PARTY LIABILITY RECOVERY

- A. The provider shall utilize and require its subcontractors to utilize, when available, covered medical and hospital services or payments from other public or private sources, including Medicare.
- B. The provider shall attempt to recover, and shall require its subcontractors to attempt to recover, monies from third party liability cases involving workers' compensation, accidental injury insurance and other subrogation of benefit settlements.
- C. The Department shall notify the provider of any reported third party payment sources.
- D. The provider shall verify third party payment sources directly, when appropriate.
- E. Payment of State and Federal funds under the District's State Plan for Medical Assistance to the provider shall be conditional upon the utilization of all benefits available from such payment sources.
- F. Each third party collection by a provider for a Medicaid recipient shall be reported to the Department and all recovered monies shall be returned to the Department immediately upon recovery.

VI. SANCTIONS FOR NON-COMPLIANCE

If the Department determines that a provider has failed to comply with the applicable Federal or District law or rule, or any law or order that prohibits discrimination on the basis of race, age, sex, national origin, marital status or physical or mental handicap, the Department may do all of the following:

- A. Withhold all or part of the providers' payments; and/or,
- B. Terminate the Agreement within 30 days from date of notice to the provider
- C. Before taking action described in VI, A & B, the Department shall provide written notice to the provider which shall include:
 - 1. Identification of the sanction to be applied;
 - 2. The basis for the Department's determination that the sanction should be taken;
 - 3. The effective date of the sanction; and,
 - 4. The timeframe and procedure for the provider to appeal the Department's determination.
- D. The termination of the Agreement shall not discharge the responsibilities of either party with respect to services or items furnished prior to termination, including retention of records and verification of overpayment or underpayment.

- E. Upon termination, the provider shall submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form prescribed by the Department. Invoices submitted not later than thirty (30) days following the termination date shall be paid.
- F. The provider also shall submit to the Department all financial performance and other reports required as a condition to this Agreement within ninety (90) days of the termination date.
- G. The Department reserves the right to terminate this Agreement immediately if:
 - 1. The United States Department of Health withdraws Federal financing participation in all or part for the cost of covered services;
 - 2. District funds are unavailable for the continuation of the Agreement;
 - 3. The Department is notified by the appropriate District agencies, or other appropriate licensing or certifying bodies that the licenses and/or certification under which it operates have been revoked, expired and/or will not be renewed; or,
 - 4. The owners, officers, managers or other persons with substantial contractual relationships have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act.
- H. The Department reserves the right to terminate this Agreement or take some other enforcement act consistent with Federal and District law and regulation in the event of default of the provider.
- I. The following shall trigger use of an enforcement action against a provider:
 - 1. Inability of the provider to provide the services described in this Agreement;
 - 2. Insolvency of the provider;
 - 3. Failure of the provider to maintain its licensure or accreditation;
 - 4. Violation of any provision of applicable Federal or District law or implementing rules.
- J. The provider shall be responsible for providing written notice to recipients thirty (30) days prior to the effective date of the termination in the form prescribed by the Department and shall be responsible for notifying the Department of those recipients who are undergoing treatment of an acute condition.
- K. The Department may, at its sole discretion, offer to re-negotiate any provision of this Agreement if such re-negotiation would mitigate or eliminate any of the causes of termination s specified.

VII. ASSIGNMENT OF RIGHTS

The rights, benefits and duties included under this Agreement shall not be assignable by the provider without receiving the written approval of the Department. The Department, as a condition of granting such approval, shall require that such assignees be subject to all conditions and provisions of this Agreement and all Federal laws and rules governing the assigned Agreement.

VIII. TERMINATION OR REDUCTION OF THE DEPARTMENT'S SOURCE OF FUNDING

The Department's obligation to pay funds for the purpose of this Agreement is limited solely to availability of Federal and District funds for such purposes. No commitment is made by the Department to continue or expand such activities.

IX. CONFIDENTIALITY OF INFORMATION

- A. All information, records and data collected and maintained by the provider or its subcontractor relating to eligible Medicaid recipients shall be protected by the provider from unauthorized disclosure;
- B. Except as otherwise provided in Federal law or rules, use or disclosure of information concerning recipients shall be restricted to purposes directly related with the administration of the Medicaid program;
- C. Purpose directly related to the Medicaid program shall include the following:
 - 1. Establishing eligibility;
 - 2. Providing services; and,
 - 3. Conducting or assisting in an investigation, prosecution, civil or criminal proceeds relating to the administration of the Medicaid program.
- D. The type of information to be safeguarded shall include all information listed in 42 CFR 431.305.

X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider attains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I/We agree that the receipt by the D.C. Medicaid program of the first and each succeeding claim for payment from me/us will be the Medicaid program's understanding of my/our declaration that the provisions of this Agreement and supplemental providers manuals and instructions have been understood and complied with:

_____ Provider's Signature	_____ Date
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Corporate Name of the Group, Institute, Medical Facility, Firm or Government
(i.e., the Provider Entity)

_____ Address	_____ Phone Number
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Signature of individuals responsible to enforce compliance with these conditions

_____ Chief Executive Officer (if applicable)	_____ Date
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_____ Chief Medical Officer (if applicable)	_____ Date
--	---------------

_____ Principal Corporate Officer (if applicable)	_____ Date
--	---------------

Accepted by:

_____ Calvin Kearney, Chief Program Operations Department of Health Medical Assistance Administration	_____ Date
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For Official Use Only

D.C. Medicaid Provider Number Assigned: _____

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type See Specific Instructions on page 2.	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ <input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number								
or								
Employer identification number								

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as" (DBA) name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7,

Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt from backup withholding* above.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

²Circle the minor's name and furnish the minor's SSN.

³You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	-42CFR 51a.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original copy to the State agency; retain the photocopy for your files.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I — Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II- Self-explanatory

Item III- List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined, as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity, which may be maintained, by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII- Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV- (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate that date in the appropriate space.

Item V- If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI- If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII- A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII -If yes, list the actual number of beds in the facility now and the previous number



DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Identifying Information

(a). Name of Entry	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address	City, County, State		Zip Code	

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

- A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX?

☐ Yes ☐ No

- B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX?

☐ Yes ☐ No

- C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

☐ Yes ☐ No

- III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

- (b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify)

- (c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

- (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No

Name	Address	Provider Number



IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☐ No
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☐ No
If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☐ No
If yes, when _____

V. Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☐ No
If yes, give date of change in operations _____

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☐ No

Name

EIN#

Address

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No
If yes give year change _____

Current Beds _____ Prior beds _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE D. C. STATE AGENCY AS APPROPRIATE.

Name of Authorized Representative (Type

Title

Signature

Date

Remarks



**MEDICAL ASSISTANCE ADMINISTRATION
RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS
SUPPLEMENTAL APPLICATION**

Complete the information below and submit to the Medical Assistance Administration for enrollment as a provider of Residential Treatment. Please check one of the following.

____ Intermediate Residential Treatment

____ Intensive Residential Treatment

____ Other (please specify) _____

An agency may apply to be a Medical Assistance Administration Residential Treatment Provider by completing this form and submitting required documentation. Separate applications are to be submitted for each site. Where the space allotted for any response is inadequate, please attach an additional sheet.

1. Name of provider agency _____

2. Address _____

3. Name and title of administrator _____

Telephone _____

4. Description of service(s) provided _____

5. Licenses and accreditations (list all that are applicable and attach copy of verification)

6. Describe the physical facility, including location, buildings, grounds and how they are used by the children served.

7. Program description

8. Treatment philosophy

9. Treatment modalities used

10. Provide a description of the education program in which the children participate.

Do children participate in local public school program? _____

Is there an on-campus school program? _____

If so, how is it certified or accredited? _____

How will children be assessed for the appropriate educational experience?

Additional information regarding educational program

11. Attach data regarding all treatment and direct care staff. List staff according to categories (suggested categories are direct care, treatment, medical, etc.) Show for each staff member position held, educational qualifications, gender and ethnicity.

12. Attach a count by residential unit of the gender and ethnicity of each child in placement at the time of the application (cumulative count of children, not individually identified).

13. Provide a description of the process by which children are considered for admission.

14. Describe behavior management and discipline used.

15. Describe community activities and community involvement for children served.

16. List methods used to ensure that services are provided in a manner which is sensitive to the cultural diversity of the population served.

17. Describe methods used to assure maximum involvement of the families of children in treatment.

18. Describe procedures used to investigate and report any allegation of maltreatment made by or on behalf of any child in the program.

19. Provide characteristics of children appropriately served in the program.

20. Provide characteristics of children who are not appropriately served.

21. List the criteria used to determine when a child's treatment is successfully completed.

22. List the criteria for discharge in addition to successful completion of treatment.

How much notice is given? _____

Describe any provision for services to children who experience crises, such as additional or supplemental services to prevent negative emergency discharges.

23. Describe the discharge planning process and the after care service provided.

Number of children in the program at the date of application _____

Total number served for the last fiscal year _____

For the last two fiscal years (including current year), how many children were discharged?

Attach the length of stay for each discharge, reason for discharge, and placement outcome upon discharge.

24. How is the program evaluated? Describe the methodology used and give data regarding results.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration



Dear Medicaid Provider:

As an added service for our Medicaid providers, the Medical Assistance Administration (MAA) is offering the direct deposit option for your Medicaid claims payments. MAA implemented the direct deposit program for all Medicaid providers in 2003. As a result, this program enabled the District of Columbia to realize cost savings and increase efficiencies by replacing claims payment checks with electronic transfer of funds to Medicaid providers.

Your money will be credited directly to your account within 48 hours after the District's Office of Finance and Treasury (OFT) releases payment to all vendors. You will continue to receive the standard Medicaid remittance advice informing you of each direct deposit transaction.

To take advantage of the convenience and speed of direct deposit, please complete the enclosed (4) forms, make a copy for your records and return the originals to the following address. Enclosed are instructions to follow for completing the forms.

ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043

To ensure timely processing, the enclosed forms listed below need to be completely filled out.

- Medicaid Provider ACH/Direct Deposit Enrollment Form
- W-9 Form – Request for Taxpayer Identification & Certification
- Direct Deposit Authorization Form
- Supplier/Vendor Information Form

Please allow four to six weeks to establish your direct deposit account. If you have any questions regarding this option, please contact William Brown at 202-698-2008.

Sincerely,

Calvin Kearney
Chief, Program Operations
Medical Assistance Administration

INSTRUCTIONS

For

Completing Direct Deposit Enrollment Forms (4)

The following instructions will assist you in completing the four (4) forms listed below. It is necessary to give full and accurate information for each question to ensure enrollment in the District of Columbia Medical Assistance Administration's (MAA) Direct Deposit Plan. If you have more than one Medicaid provider number (assigned by ACS), you will need to complete a complete packet (4 forms) for each Medicaid provider number.

Return all completed forms to ACS as soon as possible. Please direct all questions regarding these four (4) forms to the Provider Services Unit at 202-906-8318 or William Brown at 202-698-2008. Allow 6-8 weeks processing time.

1. Medicaid Provider ACH/Direct Deposit Enrollment Form

(Please complete all fields)

Please complete all fields and have this signed by the Chief Financial Officer or authorized representative.

- Name of Provider – actual provider name
- Medicaid Provider Number – 9-digit number assigned by ACS
- Federal Tax Identification Number
- ABA/Routing Transit Number – checking account information from bank
- Address, City, State, Zip – address of provider
- Point of Contact – person to contact for additional information
- Section 2 – have CFO print and sign this section

2. W-9 Form – Request for Taxpayer Identification & Certification

(Provide “either” your Employer Tax ID number or Social Security number – do not provide both!)

Detailed instructions are on pages 2, 3, and 4 of the form. Enter information that is on file with the Internal Revenue Service (IRS).

- Name – enter your “company name” or the name of your organization as registered on file with the IRS on Line #1; only complete Line #2 if the “company name” is different.
- Business Name – list trade names used, if any
- Type – if incorporated, select “Corporation”
- Address – enter address on file with the IRS
- Part I – enter employer identification number (i.e., TAX ID); only provide your Social Security number if you do not have an employer identification number
- Part II – have appropriate official (i.e., CEO, CFO, VP) sign and date form
- Print the name of the person signing the form directly below the signature line

3. Direct Deposit Authorization Form

(Your bank must complete and sign this form)

Complete Sections 1 and 2. Your BANK must complete, verify, and sign Sections 1 and 3. An official bank representative must sign and date the form. You can also include a “voided” deposit slip for the account that claims payments should be transmitted to.

- Name of Person entitled to Payment – enter name of organization
- Government Agency Name – agency name and/or department
- Government Agency Address – address of agency and/or department
- Name and Address of Financial Institution – enter bank name and branch
- Type of Depositor – select “Checking”
- Depositor Account Number – enter checking account number
- ABA/Routing Transit Number – have bank complete this section

4. Supplier/Vendor Information Form

(Complete Sections 1 and 3)

Column 1, Row 1 – select “New Vendor
Business Entity Section

- Attorney – select “N” for no
- Supplier Vendor Type – select 5 for vendor-business and circle (5) on page 2, question #6
- Ownership Code – select “N” for medical corporation and circle (N) on page 2, question #7 Note: If address in question #1 is out of the District of Columbia, select “O” for out of state corporation
- Enter address information provided on all forms
- 1099 – circle “N” for no

Payment Address

- One Time Payment – leave this blank
- Question 3 – enter address and telephone number of your banking institution (branch level or main office; cannot be a P.O. box)

Section 5 – leave blank. The Medical Assistance Administration will complete this section.

Section 6 – circle “5” for vendor-business

Section 7 – circle “N” for medical corporation

MAA must receive “original” copies and signatures so they may be placed in your permanent file. Please review your completed for prior to submission and return all four (4) original forms together as soon as possible to:

**ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043**

Questions – contact Provider Services at 202-906-8318



**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION**

2100 MARTIN LUTHER KING, JR. AVENUE, SE
SUITE 302
WASHINGTON, DC 20020

**MEDICAID PROVIDER
ACH/DIRECT DEPOSIT ENROLLMENT FORM**

SECTION 1

(All fields must be completed)

Name of Provider _____
Medicaid Provider Number (9-digit number assigned by ACS) _____
Federal Tax Identification Number _____
Bank Account Number _____
ABA/Routing Transit Number _____
Address _____ State _____ Zip _____
Point of Contact _____ Telephone Number _____

SECTION 2

(To be completed by the Chief Financial Officer or Authorized Representative)

CERTIFICATION

I confirm the identity of the above Medicaid provider, name, provider number, federal tax identification number, bank account number, and routing number. As a representative of the above named Medicaid Provider, I certify that the information is correct and the provider approves of the direct deposit option.

CFO or Authorized Representative _____
(print or type)

Signature of Representative _____

Telephone Number _____ Date _____

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

Name	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ <input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number								
or								
Employer identification number								

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Direct Deposit Authorization Form

Government of the District of Columbia
Office of the Chief Financial Officer
Office of Finance and Treasury

(Please read the reverse side carefully before completing this form)

SECTION 1
(TO BE COMPLETED BY PAYEE)

A. NAME OF PAYEE (last, first, middle initial)			B. ORGANIZATION CODE ID:		
ADDRESS (street, route, P.O. Box, APO/FPO)					
CITY	STATE	ZIP	C. NAME AND ADDRESS OF FINANCIAL INSTITUTION		
TELEPHONE NUMBER					
HOME WORK					
NAME OF PERSON(S) ENTITLED TO PAYMENT					
SOCIAL SECURITY NUMBER			D. TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
GOVERNMENT AGENCY NAME					
GOVERNMENT AGENCY ADDRESS			E. DEPOSITOR ACCOUNT NUMBER		
			F. ABA/ROUTING TRANSIT NUMBER		

SECTION 2

PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS CERTIFICATION (optional) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

SECTION 3
(TO BE COMPLETED BY FINANCIAL INSTITUTION)

FINANCIAL INSTITUTION CERTIFICATION I confirm the identity of the above named payee(s) and the account number, routing number and title. As a representative of the above named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above.			
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE



GOVERNMENT OF THE DISTRICT
OF COLUMBIA



Page 1 of 2

New Vendor <input type="checkbox"/> CHECK New Payment Address <input type="checkbox"/> ONLY New Business Address <input type="checkbox"/> ONE Deactivation <input type="checkbox"/>	SUPPLIER/VENDOR INFORMATION FORM
Business Entity Applicable Y/N Supplier/Vendor Type: _____ (From Page 2) Ownership Code: _____ (From Page 2)	1. As information appears in official records: (ALL FIELDS MUST BE COMPLETED) Federal Taxpayer ID _____ Social Security Number _____ 1099 Y/N <small>see 1099 requirements</small> Corporate Name: _____ Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____ Contact _____ Fax: _____
Individual Applicable Y/N Supplier/Vendor Type: _____ (From Page 2) Ownership Code: _____ (From Page 2)	2. In an individual rather than a business entity: (ALL FIELDS MUST BE COMPLETED) Social Security Number _____ Individual's Name: _____ Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____ Fax: _____
Payment Address One Time Payment: <input type="checkbox"/>	3. To which all payments will be sent: Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____
Additional Payment Address	4. New additional payment address: Suite/Room: _____ Street: _____ City: _____ State: _____ Zip: _____ Telephone _____
Authorization Date Faxed ____/____/____ URGENT: Court Order: <input type="checkbox"/> DCMR 1710 Emergency: <input type="checkbox"/>	5. INFORMATION PROVIDED BY: Print or Type Name of Requestor _____ Title _____ Phone _____ Fax _____ 3 digit Agency Code _____ Agency Chief Contracting Officer (ACCO) _____ Date _____ Agency Chief Financial Officer (ACFO) _____ Date _____

FMS Form 710R (REV. 3/02)

[OVER]

VENDOR INFORMATION FORM

Page 2 of 2

<p>FAX OR DELIVER TO: DIVISION OF VENDOR ENTRIES 810 FIRST STREET, N.E. SUITE 200 WASHINGTON, DC 20002 FAX: (202) 442-8217 For Assistance, call Division of Vendor Entries at (202) 442-8269</p>	
Vendor Type	<p>6. (Please circle one):</p> <ul style="list-style-type: none">1. Employee2. Federal Agency3. State Agency4. Local Government5. Vendor-business6. Vendor-Individual7. Other
Ownership Code	<p>7. (Please circle one):</p> <ul style="list-style-type: none">A. State CorporationC. Professional CorporationE. State EmployeeF. Financial InstitutionG. Government EntityI. Individual RecipientL. Local Small Disadvantage Business EnterprisesN. Medical CorporationO. Out of State CorporationP. Professional AssociationR. ForeignS. Sole OwnershipT. Partnership

FMS Form 710R (REV. 3/02)

